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Towards a Consumer Focused Primary Health and Community Support System

A response to the Aged, Community and Mental Health discussion paper **Towards a Stronger Primary Health and Community Support System** (June 1998)

The Co-operative Federation of Victoria Ltd welcomes the Aged, Community and Mental Health discussion paper : **Towards a Stronger Primary Health and Community Support System.** (June 1998)

It is stated at the beginning of the discussion paper that: "Unfortunately, attention is seldom given to how well these services function for consumers as a complete service system." This statement is timely and we welcome the opportunity to comment on consumer benefit as expressed through co-operative action. It is further stated in the discussion paper that it is "the first steps forward for Victoria in examining the existing service system and proposing how it might be strengthened to meet the needs of the next century." We welcome this stated openness and the discussion paper's assertion that it provides "a blueprint for a consumer-focused services system that will form the basis of the Victorian health and community service system into the next century."

The focus of this submission is consumer and provider empowerment through co-operative action and how this is central to a consumer-focused services system. We all need to remind ourselves that to claim and assert a consumer-focused service system is not the same as its achievement and, indeed, it is impossible to create a "perfect" system and the ongoing challenge is to reinvent a consumer-focus.

The discussion paper is examined initially in terms of the philosophical underpinning of its objects and how this relates to the practicalities of consumer and provider empowerment. The specific proposals for the reorganisation of the health and community service system are, then, examined in terms of what opportunities there could be for co-operative action for consumers and providers and whether the specific proposals could facilitate or hinder this development. Finally, there is consideration of the precedents of and potential for co-operative development and how this could be facilitated through consumer and provider co-operatives and the need to facilitate this potential now – rather than later.

Philosophical Underpinning

The discussion paper notes that: "The State Government is not a service provider in this sector, but together with the Commonwealth Government and local government is a purchaser of services on behalf of consumers. " (p 11)

The role of Government in purchasing for consumers is recognised but questioned as to the ultimate appropriateness of government assuming the role of purchasing for consumers and how in exercising this role government avoids its own interests and demands. Government does have a responsibility in establishing and monitoring the quality of service and standards. This does not equate, however, to being a purchaser on behalf of consumers.

The policy outcome of packaging services "around the needs of consumers" is supported.(p12) It is noted also in the discussion paper that "services need to be provided according to the needs of individuals rather than according to funder or provider driven interests or demands." (p 12) This is supported yet could be contradicted by the previous assertion that government is a purchaser of services on behalf of consumers.

Given this, the key issue is how government as funder avoids government driven interests and demands – as well as provider driven interests and demands. It is regrettable that this fundamental issue is not explicitly addressed in the discussion paper. Instead, it is implied that government has an inherent capacity to transcend its own interests and demands. Government does have an obligation to vigorously scrutinise the performance of providers. The same vigorous scrutiny should also be acknowledged as applying to government as a purchaser.

Self-help is narrowly defined and described in the discussion paper: "Facilitating self-help is an effective strategy for a range of social and health problems including the management of chronic illness, alcohol and drug problems, mental health and parenting and relationship difficulties." (p 48) Self-help and carer support services, then, are to be "closely integrated with other independent living services and general care services, through which access will be coordinated." (p 48)

Self-help as expressed through the co-operative model is not recognised, then, as an appropriate organisational option. Instead, it is appropriate for a specific range of services.

The discussion paper does encourage diversity in the following terms: "The emphasis here is on outlining the characteristics required in the system of services rather than on specifying the means by which these are to be achieved. It would be expected that, within parameters, individual local or regional approaches to meeting these requirements and varying rates of evolution towards them will be the reality of the reform process." (p 11) But, this envisaged diversity is of providers to consumers. There is no explicit recognition of the possibility of consumers as providers through their own locally owned and controlled co-operatives.

Throughout the discussion paper there is an implicit separation of providers and consumers with an emphasis on what providers should do for consumers and the role of government in defining and protecting the consumer interest. While the issues would be the same for a consumer owned and controlled co-operative, the assumption remains that consumers will not also be providers. 'Clear and accurate information for consumers and other providers will also be required to assist access and referral." (p 12) "access to language services, strong links to ethno-specific services where available and regular monitoring of performance in areas such as the representation in a provider's client population of the demographics of their catchment population." (p 12)

The term provider is used generically and there is no recognition that different structural arrangements already exist which includes member-owned providers such as co-operative hospitals, friendly society dispensaries and aged care facilities, bush nursing hospitals and centres and co-operative general practices. In not identifying different providers, the discussion paper avoided the need to examine whether different providers had a different consumer-focus. This also avoided the need to examine whether the member-owned providers have a unique contribution to make to an overall commitment to consumer-focussed services. In a recent survey in the USA Americans have indicated, for example, a strong preference for community-owned hospitals rather than investor-owned hospitals The survey was undertaken

in 1997 by Market Strategies Inc seeking the opinions of 1000 consumers in the top 100 Metropolitan Statistical Areas. The community-owned hospitals are preferred 4-to-1 over investor-owned hospitals.

The discussion paper's limited view of consumers is further reinforced with this question: "What does this mean in human terms, for the consumers of these services?" (p 13) It is an appropriate question but the paper's own response is limited: "It means that an individual should be able to make initial contact with any part of the system and have their needs responded to promptly and in an appropriate way." (p 13) It is further stated: "The system of services needs to be broad enough to allow for the selection of the most appropriate service response for an individual." (p14) It is symbolic that the word "for" is used instead of "by". It is also stated that: "All these choices should be considered and all should be available if the most appropriate and effective assistance is to be provided." (p 14) There is a fundamental correctness in the discussion paper's emphasis on choice as integral to an appropriate service system. Consumers should have choices but at issue is what choices and how is it possible for consumers to exercise an informed choice – rather than submitting to the choices of funder and providers.

Practice

Integration is a key concept used to describe an appropriate service delivery system." That is, a system where service providers and consumers in an area operate as a team to plan, monitor and review, as well as provide a system of well coordinated services focused on consumer outcomes." (p 27)

A focus on consumer outcomes is appropriate as is integration if it achieves desired and appropriate consumer outcomes – as required by consumers. Of course, there is a need to address the asymmetry in information and relationships and it is disappointing that this is not acknowledged as conditioning consumers and providers operating "as a team." Nor is the implicit assumption that government will oversight the balance of the relationship an adequate safeguard in itself.

The characteristics of the integrated system are summarised as follows:

- System-wide resource allocation, Information Technology (IT) development, human resource planning and strategic decision making.
- System-wide quality assurance and performance management systems.
- A single point of reporting and accountability to purchasers and community.
- Multi-disciplinary care planning and service delivery.
- Shared assessment, referral and records systems and a joint after hours response capacity.
- System-wide protocols and service delivery policies.
- Coordination of input from consumers and the communities served.
- Strategic networks with other related providers from different sectors such as local government, non-government providers, GPs, health care networks and hospitals. (pp 27-28)

It is further proposed that: "An integrated service system will undertake collaborative service system planning, monitoring and review, including identifying and respond-

ing to service gaps." (p 28)

It is suggested that there are a variety of structural optioned but that structural reforms alone will not ensure greater coordination or integration. (p 28) Structural options are not identified and, hopefully, this reflects an openness to a diversity of options. It would have been useful, however, for the discussion paper to have identified options for it is in the structural expression of objects and frameworks that it is possible to test the meaning of stated philosophy. Nonetheless, the proposed demonstration projects are a way to move forward and could provide the basis for a broad development and an open examination of options – provided the demonstration projects are sufficiently broad-based. There is a disquieting suggestion that there are "limits to the potential for open market testing at this time." (p 37) Instead, it is argued that: "The overwhelming priority is for collaboration amongst providers to establish strong relationships." (p 37) The argument has merit but could also entrench existing providers albeit in new configurations and relationships and, therefore, be deemed to be anti-competitive and consumer choice. At a minimum, therefore, the discussion paper should have discussed this issue at length rather than rely on the obviousness of its own statement – and, presumably, the appeasement of existing providers.

Subsequently, in considering the structural options and demonstration projects it is suggested that: "Consortia or alliances of providers are most likely to emerge as the dominant service provider arrangement for the delivery of PHAS services. Within each catchment a lead-agency or body corporate style of arrangement will be required to act as the fundholder and coordinating mechanism for the consortia or alliances." (p 37)

It is also suggested that expressions of interest will be sought from "partnerships of providers" (p 37) and that "successful partnerships will therefore be most likely to involve existing providers of sub-regional and of local services who can develop the capacity to work collaboratively in establishing a complex, yet well integrated, client focused system." (p 37) The comments are practical and reasonable but should not exclude the possibility of new providers who have been excluded by the structure of the existing system by funders and other providers and, in particular, addressing the needs of rural areas and disadvantaged urban areas. Otherwise, there will be a tendency to entrench existing providers and, therefore, ultimately, frustrate the notion of an open market. The discussion paper has suggested that: "Open market testing may be possible in future years." (p 37) If there is to be a commitment to open market testing in future years, then, this should not be on the basis of entrenching existing providers. The discussion paper position on an open market is unclear and the "if" suggests there has been no decision. If open market testing is a possibility in the future, then, the issue of entrenching existing providers does need to be considered in the context of competitive neutrality.

Co-operative Development

The demonstration projects are creating opportunities for two types of co-operatives – consumer co-operatives and provider co-operatives. Before discussing these, it is important to understand the philosophy and principles of co-operation.

Cooperatives are based on the values of self-help, self-responsibility, democracy, equality, equity and solidarity. In the tradition of their founders, co-operative members believe in the ethical values of honesty, openness, social responsibility and caring for others.

Co-operative Principles.

- **Voluntary and Open Membership** – Cooperatives are voluntary organizations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination.
- **Democratic Member Control** – Co-operatives are democratic organizations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary co-operatives, members have equal voting rights (one member, one vote) and co-operatives at other levels are organized in a democratic manner.
- **Member Economic Participation** – Members contribute equitably to, and democratically control, the capital of their co-operative. At least part of that capital is usually the common property of the co-operative. They usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing the co-operative, possibly by setting up reserves, part of which at least would be indivisible; benefiting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.
- **Autonomy and Independence** – Co-operatives are autonomous, self-help organizations controlled by their members. If they enter into agreements with other organizations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their co-operative autonomy.
- **Education, Training and Information** – Co-operatives provide education and training for their members, elected representatives, managers and employees so they can contribute effectively to the development of their co-operatives. They inform the general public – particularly young people and opinion leaders – about the nature and benefits of co-operation.
- **Co-operation among Co-operatives** – Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national, regional and international structures.
- **Concern for Community** – While focusing on member needs, co-operatives work for the sustainable development of their communities through policies accepted by their members.

The Co-operative Federation of Victoria Ltd has recently released a number of booklets that are relevant to the development of primary health and community support services and these should be read in conjunction with this submission:

⇒ **Co-operatives and Public Policy, 1998**
⇒ **Opportunities for Co-operatives in Health Care, 1997**
⇒ **Shared Services Co-operatives for Community Agencies, 1998**
⇒ **Social Care Co-operatives, 1998**
⇒ **The Co-operative Model, 1998**

The Federation has also developed a proposal for associations of health consumers and this should also be examined:

⇒ **Associations of health consumers: the key to health care reform, 1997**

Specific observations are now offered on provider and consumer co-operatives.

Provider co-operatives. The development of partnerships, consortia or alliances is a challenge to providers in the primary health and community support providers. The initial challenge, obviously, is to work together in new ways. The next challenge is the basis of this working together and whether or not there is an interest in protecting the autonomy and independence of individual providers while equally achieving integration of services and cost efficiencies. This crucial choice is not addressed by the discussion paper. Nonetheless, it is a vital consideration.

The co-operative model provides a unique opportunity to achieve integration and efficiencies with provider independence and autonomy. This is why some providers in the USA, for example, have adopted co-operatives as their preferred consortia and alliance model. They needed to remain competitive and achieve efficiencies but they also wished to retain their autonomy and independence and not be part of a consortia or alliance which had unequal partners.

The Rural Wisconsin Health Co-operative, for example, is owned and operated by 21 rural acute, general medical-surgical hospitals and one urban hospital. The co-operative was established in 1979. The Pioneer Health Network is comprised of 17 southwest Kansas and northwest Oklahoma hospitals. The co-operative was established in 1997 to provide an integrated health delivery system that respects member autonomy while focusing on common ground issues which enhance health services, promotes healthier communities and accommodates changing conditions throughout the services area while helping to reduce member operating costs. The VHA is a co-operative – a national network of 1600 community owned health care organisations and their physicians. The members represent 22% of the USA's community hospitals. The VHA has 1000 employees and its services include supply chain management, learning networks and education, performance improvement, information technology and market share development.

What the co-operative model allows is for individual agencies to remain autonomous and independent yet provide together an integrated service with cost efficiencies. A co-operative model would protect the interests of small agencies in particular and would prevent intercine struggles for power and dominance within a consortia or alliance. The relatively simple reason for this is that a co-operative consortia or alliance is created to serve all members equally who all have one vote per member irrespective of their size. Of course, it also depends on an understanding and acceptance of co-operative democracy.

Consumer Co-operatives There are existing precedents for consumer co-operatives which are not mentioned in the discussion paper. In the 19thC a large proportion of doctors were employed by consumers through friendly societies. By the 1980's, however, this system of consumer-based health provision had been eliminated through policies and practices of respective governments. Friendly societies still persist, however, in providing health insurance and aged care services. Friendly society dispensaries also survive from the 19thC.

The Yallourn Medical and Hospital Society is a friendly society based on the electricity industry workforce in the Latrobe Valley in Victoria. It provides health insurance products, two medical clinics and has a half share in a private hospital. The bush nursing movement in Victoria has 25 small hospitals, 20 nursing homes, seven hostels and 15 bush nursing centres. These are run by local committees elected by members. South Kingsville Health Services Co-operative provides medical, dental and allied health services in the western suburbs of Melbourne. It is an independent enterprise. In NSW there are four co-operative community hospitals.

A primary care co-operative could be formed by consumers in particular communities to provide integrated medical, dental, allied health, pre-admission and post-discharge services, post acute care, home-based maternity services, community-based aged care and mental health services, health promotion and community rehabilitation. The emphasis would be on the provision of continuity of care in an integrated multi-service community-based setting.

A cooperative of this type could be formed in any community but could be in particular formed in communities which are currently poorly serviced by existing service models such as rural areas and disadvantaged areas or in communities which are dissatisfied with the quality of existing services. The establishment of consortia and alliances from existing providers will not necessarily resolve the difficulties of poorly serviced rural areas and disadvantaged areas and could even exacerbate the difficulties by allowing external providers to service these areas remotely.

Consumers could form hospital co-operatives to either maintain or introduce a local hospital service. In 1988 the community of Yeoval in the central west of NSW was faced with the closure of its local hospital. A co-operative was formed to keep it operating and today it functions as an innovative community care centre. A community owned and controlled hospital could be an alliance of individuals and organisations.

Another option is for a purchasing co-operative or a co-operative to include a purchasing function – to enable consumers to negotiate and enter contracts with providers for the supply of health services and products. Negotiations could be undertaken with a provider of health insurance for the supply of insurance products. Negotiations could also be undertaken with particular fee-for-service providers in allied health, optical, dental and pharmacy to secure discounted prices for members.

Co-operatives of consumers can critically address the information asymmetries between providers and consumers by enabling comparative price and service quality and enabling consumers to individually or collectively purchase their preferred services from which providers – a choice that is consumer driven rather than being driven by funders and providers.

Some of the features of associations of consumers would include consumers having the option of joining an association of their choice, membership would be